Medical Declaration

THE MCLENNAN GROUP INSURANCE INC.

For non-medical trips over $20,000

Travel Choice 2

Call 1-800-509-5831, one of our representatives will be happy to assist you.
Our office hours are 8:30 a.m. to 8:00 p.m. Monday to Friday and 9:00 a.m. to 5:00 p.m. on Saturday (ET)

First Name: _____ Last Name: _____ (Maiden for Quebec Only)

Address: _____

Date of Birth: _____ (dd / mm / yy) ☐ Male ☐ Female Departure Date: _____ (dd / mm / yy) Return Date: _____ (dd / mm / yy)

Furthest Travel Destination: _____ Trip Value: $_____ Sum Insured: $_____

Number of Travel Companions: _____ Type of Trip: ☐ Land ☐ Cruise ☐ Adventure ☐ Other: _____

Travel Companion relationship to you: _____ Purpose of Trip: ☐ Leisure ☐ Business (specify below) ☐ Other (specify below)

Attach copy of the trip itinerary, and trip cancellation penalties (if applicable). Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. Call 1-866-943-5997 for a copy of the Privacy Policy.

DEFINITIONS - Please refer to the following definitions for words where notations 1 through 2 appear on this Medical Declaration.

1**. Treatment/Treated** means a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a licensed medical practitioner, including but not limited to prescribed medication, investigative testing and surgery related to any sickness, injury or symptom.

2. **Stable -** a medical condition is stable if all of the following apply during the specified stability period:
- you have not had any new symptom(s); and
- existing symptom(s) have not become more frequent or severe; and
- your physician has not determined that your medical condition has become worse; and
- no test findings have shown that your medical condition may be getting worse; and
- you have not received, been prescribed, taken or had a Physician recommend any new medication, any change in medication; and
- you have not received, been prescribed or had a physician recommend any new treatment[1] or any change in treatment[1]; and
- you have not been hospitalized or referred to a specialty clinic or specialist; and
- your physician has not advised you to see a specialist or to have further tests, and you have not undergone testing for which you have not yet received the results.

INSTRUCTIONS

This Medical Declaration must be completed at the time you purchase your trip or prior to any cancellation penalties being applicable for your trip. ONLY YOU can complete and sign this Medical Declaration, not your spouse or sales agent.

STEP 1: Complete the Personal Information section.
STEP 2: Complete the Eligibility Criteria section.
STEP 3: Complete PART A to PART F by checking off either YES or NO to each question.
Note: If you have any doubt about your health as it relates to the questions asked, you must consult a physician for advice before completing the Medical Declaration.
STEP 4: Be sure to read, understand and sign the Agreement, Understanding and Authorization section.
Note: Should you need to make a correction to your answers pertaining to the medical questions in this Medical Declaration after you have submitted it, please call your sales agent for instructions.

THE ANSWERS YOU PROVIDE WILL, IN THE EVENT OF A CLAIM, BE REVIEWED FOR ACCURACY BY THE INSURER. IF THEY ARE INACCURATE IN ANY WAY, YOUR CLAIM WILL BE DENIED.

ELIGIBILITY CRITERIA			
IMPORTANT: This travel insurance is only available to you if you are a Canadian resident or landed immigrant and you answer NO to questions 1 to 4 below. If you must answer **YES** to **any questions in this section**, you are **NOT ELIGIBLE** to purchase this insurance.		ANSWER:	
1.	Are you travelling against the advice of a physician or have you been diagnosed with a terminal illness? A "terminal illness" means that you have a medical condition that is cause for a physician to estimate that you have less than 6 months to live or for which palliative care has been received.	YES	NO
2.	Do you have a kidney disease requiring dialysis?	YES	NO
3.	During the **12 months** prior to your departure date, have you been prescribed or used home oxygen?	YES	NO
4.	Have you **ever** been diagnosed with AIDS (Acquired Immune Deficiency Syndrome)?	YES	NO
PART A – HEART CONDITION			
During the **10 years** prior to applying for this insurance:		ANSWER	
1.	Have you been diagnosed with a cardiac condition?	YES	NO
2.	Have you been diagnosed with or treated[1] for angina (chest pain)?	YES	NO
3.	Have you been diagnosed with heart failure (for example, shortness of breath, fatigue, ankle/leg swelling or edema?	YES	NO
4.	Have you used nitroglycerine (spray, patch, or pill) regularly? If YES, please indicate how often (daily, weekly, monthly):	YES	NO

5.	Have you had a heart attack? If YES, please indicate when (d/m/y):	YES	NO
6.	Have you had a coronary angioplasty? If YES, please indicate when (d/m/y):	YES	NO
7.	Have you had heart bypass surgery? If YES, please indicate when (d/m/y):	YES	NO
8.	Have you taken Lasix, Furosemide or their generics for any reason (including for high blood pressure)? If YES, please indicate dosage ___mg per day.	YES	NO
9.	Have you been diagnosed with an atrial fibrillation?	YES	NO
10.	Have you taken blood thinner for a heart condition?	YES	NO
11.	Have you been hospitalized for any other heart condition NOT listed herewith: chest pain/angina, heart attack, angioplasty, heart bypass surgery, heart failure, atrial fibrillation? If yes, please describe the diagnosis and indicate when (d/m/y):	YES	NO
PART B – LUNG CONDITION			
During the **12 months** prior to applying for this insurance:		ANSWER	
1.	Have you been diagnosed with a lung condition (including lung cancer or pneumonia)? If YES, please describe the diagnosis and indicate when (d/m/y):	YES	NO
2.	Do you use a puffer/inhaler regularly? If YES, please indicate how often (daily, weekly, monthly):	YES	NO
3.	Have you required the use of Prednisone, Deltasone or other generic? If YES, please indicate when (d/m/y):	YES	NO
4.	Have you been hospitalized for a lung condition? If YES, please describe the condition and indicate when (d/m/y):	YES	NO
PART C – STROKE/MINI-STROKE/PVD			
During the **12 months** prior to applying for this insurance:		ANSWER	
1.	Have you had a stroke (CVA) or mini-stroke (TIA)?	YES	NO
2.	Have you been diagnosed with blocked or clogged arteries in the neck or legs (PVD)? If YES, please indicate when (d/m/y):	YES	NO
3.	Have you taken a blood thinner?	YES	NO
4.	Have you been hospitalized for a stroke (CVA), mini-stroke (TIA) or peripheral vascular disease? If YES, please indicate when (d/m/y):	YES	NO
PART D – DIABETES			
During the **12 months** prior to applying for this insurance:		ANSWER	
1.	Have you been diagnosed with diabetes? If YES, please indicate how your diabetes is controlled:	YES	NO
	a) Diet	YES	NO
	b) Oral Medication	YES	NO
	c) Insulin	YES	NO
2.	Do you check your blood sugar? If YES, please indicate how often: _____Daily or _____Monthly	YES	NO
3.	Have you been hospitalized for your diabetes? If YES, please indicate when (d/m/y):	YES	NO
PART E – HIGH BLOOD PRESSURE			
During the **12 months** prior to applying for this insurance:		ANSWER	
1.	Have you been diagnosed with high blood pressure?	YES	NO
2.	Have you taken medication to control your high blood pressure?	YES	NO
3.	Have you been hospitalized for your high blood pressure? If YES, please indicate when (d/m/y):	YES	NO
PART F – OTHER		ANSWER	
1.	Have you ever had an organ transplant (excluding corneal transplant)? If yes, please indicate the type of transplant and the date (m/d/y):	YES	NO
2.	Have you been prescribed or are you currently taking medication for any medical condition NOT listed in PARTS A to E? If yes, please indicate the medication and for which medical condition:	YES	NO
3.	During the 5 years prior to your departure date, have you smoked cigarettes?	YES	NO

IMPORTANT NOTICE: If your health changes or does not remain stable[2] between the date you complete and submit the Medical Declaration and your departure date, you must review the medical questions in this Medical Declaration with your sales agent to re-assess your eligibility. If you are no longer eligible for the insurance plan you purchased and you fail to contact your sales agent, your claim will be denied, the Insurer will void your policy, and the premium you paid will be refunded. This means no benefits will be covered and you will be responsible for all expenses relating to your sickness or injury, including repatriation costs.

AGREEMENT, UNDERSTANDING AND AUTHORIZATION

You must read and understand the importance of each of the following statements and sign below.

- **A PRE-EXISTING MEDICAL CONDITION EXCLUSION** may apply to medical conditions and/or symptoms that existed prior to my trip. I understand that any medical condition I have, including those disclosed in this Medical Declaration will be subject to the pre-existing medical condition exclusion(s) of the plan I qualify for. I will refer to my policy and to the above section for the full pre-existing medical condition exclusion clause.
- I personally provided the answers on this Medical Declaration and all information disclosed is true and accurate. The Insurer will, in the event of any sickness or injury, review my prior medical history and review my answers. I fully understand that if any of my answers are inaccurate, in the event of a claim, the Insurer will void my policy and my claim will be refused. I understand that the answers on my Medical Declaration are relevant to the risk and constitute the basis of my insurance. Where I was unsure of my medical history as it relates to the medical questions, I have verified it with my physician.
- I understand the necessity of calling Active Care Management (ACM) and obtaining prior approval before seeking medical attention in case of a claim or medical emergency. The toll free telephone number can be found on my wallet card and in my insurance policy.
- Medical Authorization in Case of a Claim – I understand that The Manufacturers Life Insurance Company (Manulife Financial) and ACM may investigate my claim. By signing this Medical Declaration, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Manulife Financial and to ACM any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment[1] and copies of all hospital or medical records for the purpose of investigating my claim.

Applicant 1 First name, Last Name (Please Print) _____ Applicant 1 Signature _____ Date of Signature (dd/mm/yy) _____

Travel Choice 2 is underwritten by The Manufacturers Life Insurance Company and is administered by CanAm Insurance. Assistance and claims service is provided by Active Care Management.